



Notice of Independent Review Decision  
**Revised Report**  
**See Bold Print**

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 07/30/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Ten **additional sessions** of a chronic pain management program

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Medical necessity has been demonstrated for the requested services.

<b>Primary Diagnosis Code</b>	<b>Service Being Denied</b>	<b>Billing Modifier</b>	<b>Type of Review</b>	<b>Units</b>	<b>Date(s) of Service</b>	<b>Amount Billed</b>	<b>Date of Injury</b>	<b>DWC Claim #</b>	<b>Upheld Overturn</b>
<b>840.9</b>	<b>97799</b>		<b>Prosp.</b>						<b>Overturn</b>

**INFORMATION PROVIDED FOR REVIEW:**

1. Certificate of Independence of the Reviewer.
2. TDI case assignment.
3. Letters of denial and physician reviewer final report 06/03/10 and 06/29/10, including criteria used in the denial.
4. Psychological Diagnostic Interview 02/23/10.
5. Functional Improvement Measure 05/07/10.
6. Preauthorization request 06/23/10.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This female sustained a right shoulder, neck, head, and back injury on xx/xx/xx after a fall on a wet floor at work. Conservative care was provided, including physical therapy, injection procedures, and diagnostic studies. Significant pain remains in the right shoulder. Surgery has been recommended but denied twice. On 08/11/09 MMI was reached with a 0% impairment rating. The file was closed in 2009 but opened again pending the request for a pain management program.

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**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

ODG criteria are described in the denials. The appeal letter and program description information addresses the issues opined by the previous reviewers. A thorough evaluation has been performed, the definite goals are proposed, and the individual appears motivated and desires returning to work. Conservative care has failed, and no other options are present. ODG criteria have been met, and it is reasonable for this injured worker to participate in ten **additional sessions** of a **chronic** pain management program.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)